WESTERN CONNECTICUT HOME CARE
DANBURY HOSPITAL • NEW MILFORD HOSPITAL • NORWALK HOSPITAL

STAFF USE
Clinic Site: _____
Verified by: _____

CONNECTICUT STATE CLINICS
2015 ADULT INFLUENZA IMMUNIZATION CONSENT

Patient Name *(Full name including middle name/initial as it appears on card):*	**Gender** ☐M ☐F	**Date of Birth** ____/____/____	**Age:** _____
Address:			
No. and Street Name (No PO Box Please)	**City**	**State**	**Zip**
Home or Cell Phone:	**Work Phone:**		

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION

CONNECTICUT STATE INSURED EMPLOYEES ONLY

☐ Anthem CT State Plan
☐ Oxford CT State Plan
☐ Other _____

Name of policyholder (This is the primary insured person):

_____

Identification No.: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Do you have an allergy or have you had a reaction to gelatin, antibiotics, eggs, latex, or to any component of any of the flu vaccine? *If yes, circle which one.* (See package inserts for more information.)	☐ Yes ☐ No
2. Have you ever had a serious reaction to any of the influenza (flu) vaccines in the past?	☐ Yes ☐ No
3. Have you ever been diagnosed with Guillain-Barré Syndrome?	☐ Yes ☐ No
4. Are you intensely sick or with a fever of >100 degrees today?	☐ Yes ☐ No

THIS SECTION FOR FLUMIST ONLY (YOU MUST BE 2 – 49 YEARS OF AGE TO RECEIVE FLUMIST)

1. Do you have long-term health problems with heart disease, lung disease (including asthma), kidney disease, neurological disease, liver disease, metabolic disease (e.g. diabetes), or anemia or other blood disorders?	☐ Yes ☐ No
2. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past 3 months, have you taken medications that affect the immune system, such as prednisone, other steroids, drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have you had radiation treatments?	☐ Yes ☐ No
3. Do you live with or expect to be in close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐ Yes ☐ No
4. Are you pregnant or is there a chance you might become pregnant within the next month?	☐ Yes ☐ No
5. Have you taken an antiviral medication such as Tamiflu® (Oseltamivir), Relenza® (Zanamivir), Symmetrel® (Amantadine), Flumadine® (Rimantadine) within the last 48 hours?	☐ Yes ☐ No
6. Have you been immunized in the last 4 weeks, or will you be immunized in the next 4 weeks a with a live vaccine: Chicken Pox (Varicella); Shingles (Zostavax); Yellow Fever; MMR (Measles/Mumps/Rubella); MMRV (Measles/Mumps/Rubella/Varicella); or FluMist within the past 4 weeks?	☐ Yes ☐ No

I have received and read the Influenza Vaccine Information Statement dated 08/07/2015. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process the insurance claim or for other public health purpose. I have read the Notice of Privacy Practices. I understand I am responsible for payment to WCHC for any portion of this claim that my insurance does not cover.

☐ **I agree with the preceding statement and give my consent to receive an influenza vaccine.**

Print Name: _____ **Signature:** _____

STAFF USE ONLY

☐ **Standard** ☐ **FluMist** ☐ **T-Free** ☐ **High Dose** ☐ **Flublok**	**Brand:** _____ **Lot #:** _____ **Exp.:** _____	
Site: ☐ **L Arm** ☐ **R Arm** ☐ **Intranasal**	**Administered by:** _____	**Date:** _____ / _____ / _____